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**BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

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In the Matter of the Accusation Against:

Case No. 2011-413

PENNY PERKINS
Las Vegas, NV 89119

DEFAULT DECISION AND ORDER

Registered Nurse License No. 192219

[Gov. Code, §11520]

RESPONDENT

FINDINGS OF FACT

1. On or about December 30, 2010, Complainant Louise R. Bailey, M.Ed.,RN, in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2011-413 against Penny Perkins (Respondent) before the Board of Registered Nursing. (Accusation attached as Exhibit A.)

2. On or about September 30, 1968, the Board of Registered Nursing (Board) issued Registered Nurse License No. 192219 to Respondent. The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and expired on June 30, 2010 and has not been renewed.

3. On or about December 30, 2010, Respondent was served by Certified and First Class Mail a copies of the Accusation No. 2011-413, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record which, pursuant to Business and Professions Code section 136 and/Title 16, California Code of Regulation, section 1409.1, is required to be reported and maintained with the Board.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section

124.

5. The Certified Mail Receipt signed by Respondent was returned to our office indicating a delivery date of January 3, 2011.

6. Business and Professions Code section 2764 states:

The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to proceed with an investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license.

7. Government Code section 11506 states, in pertinent part:

(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

8. Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 2011-413.

9. California Government Code section 11520 states, in pertinent part:

(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

10. Pursuant to its authority under Government Code section 11520, the Board after having reviewed the proof of service dated December 30, 2010, signed by Kami Pratab, and the signed Certified Mail Receipt was returned to our office indicating a delivery date of January 3, 2011 finds Respondent is in default. The Board will take action without further hearing and, based on Accusation No. 2011-413 and the documents contained in Default Decision Investigatory Evidence Packet in this matter which includes:

Exhibit 1: Pleadings offered for jurisdictional purposes;

1 Exhibit 2: License History Certification for Penny Perkins, Registered Nurse License
2 No. 192219;

3 Exhibit 3: Certification of costs by Board for investigation and enforcement in Case
4 No. 2011-413;

5 Exhibit 4: Declaration of costs by Office of the Attorney General for prosecution of
6 Case No. 2011-413;

7 Exhibit 5: Affidavit of Kelly McHan and Jeff Ramos;

8 and finds that the charges and allegations in Accusation No. 2011-413 are separately and
9 severally true and correct by clear and convincing evidence.

10 11. Taking official notice of the Certification of Board Costs and the Declaration of Costs
11 by the Office of the Attorney General contained in the Default Decision Investigatory Evidence
12 Packet, pursuant to the Business and Professions Code section 125.3, it is hereby determined that
13 the reasonable costs for Investigation and Enforcement in connection with the Accusation are
14 \$4,282.75 as of March 15, 2011.

15 DETERMINATION OF ISSUES

16 1. Based on the foregoing findings of fact, Respondent Penny Perkins has subjected her
17 following licenses to discipline:

18 a. Registered Nurse License No. 192219

19 2. The agency has jurisdiction to adjudicate this case by default.

20 3. The Board of Registered Nursing is authorized to revoke Respondent's Registered
21 Nurse License based upon the following violations alleged in the Accusation, which are
22 supported by the evidence contained in the Default Decision Investigatory Evidence Packet in this
23 case.

24 a. Violation of Business and Professions Code section 2761(a)(1) -
25 Unprofessional Conduct, Gross Negligence.

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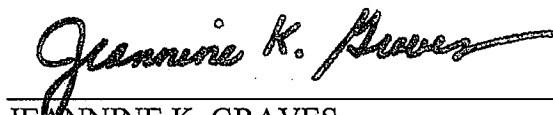
ORDER

IT IS SO ORDERED that Registered Nurse License No. 192219, heretofore issued to Respondent Penny Perkins, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on June 20, 2011.

It is so ORDERED May 20, 2011.



JEANNINE K. GRAVES
President
Board of Registered Nursing
Department of Consumer Affairs

Attachment:

Exhibit A: Accusation No. 2011-413

Exhibit A

Accusation No. 2011-413

1 EDMUND G. BROWN JR.
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2 FRANK H. PACOE
Supervising Deputy Attorney General
3 LESLIE E. BRAST
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8 **BEFORE THE**
BOARD OF REGISTERED NURSING
9 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

10 In the Matter of the Accusation Against:

Case No. 2011-413

11 **PENNY PERKINS**
12 **Las Vegas, Nevada 89119**

A C C U S A T I O N

13 **Registered Nurse License No. 192219**

14 Respondent.

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16 Complainant alleges:

17 **PARTIES**

18 1. Louise R. Bailey, M.Ed., RN (Complainant), brings this Accusation solely in her
19 official capacity as the Executive Officer of the Board of Registered Nursing (Board),
20 Department of Consumer Affairs.

21 2. On or about September 30, 1968, the Board issued Registered Nurse License Number
22 192219 to Penny Perkins (Respondent). The license was in full force and effect at all times
23 relevant to the charges brought herein; it expired on June 30, 2010, and has not been renewed.

24 **JURISDICTION**

25 3. This Accusation is brought before the Board under the authority of the following
26 laws. All section references are to the Business and Professions Code (Code) unless otherwise
27 indicated.

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1 4. Code section 2750 provides, in pertinent part, that the Board may discipline any
2 licensee, including a licensee holding a temporary or an inactive license, for any reason provided
3 in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4 5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not
5 deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or
6 to render a decision imposing discipline on the license. Under Code section 2811(b), the Board
7 may renew an expired license at any time within eight years after the expiration.

8 STATUTORY PROVISIONS

9 6. Code section 2761 states, in pertinent part:

10 “The board may take disciplinary action against a certified or licensed nurse or deny an
11 application for a certificate or license for any of the following:

12 “(a) Unprofessional conduct, which includes, but is not limited to, the following:

13 “(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing
14 functions.”

15 7. California Code of Regulations, title 16, section 1442, states:

16 “As used in Section 2761 of the code, ‘gross negligence’ includes an extreme departure
17 from the standard of care which, under similar circumstances, would have ordinarily been
18 exercised by a competent registered nurse. Such an extreme departure means the repeated failure
19 to provide nursing care as required or failure to provide care or to exercise ordinary precaution in
20 a single situation which the nurse knew, or should have known, could have jeopardized the
21 client's health or life.”

22 8. California Code of Regulations, title 16, section 1443, states:

23 “As used in Section 2761 of the code, ‘incompetence’ means the lack of possession of or
24 the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and
25 exercised by a competent registered nurse as described in Section 1443.5.”

26 9. California Code of Regulations, title 16, section 1443.5 states:

27 “A registered nurse shall be considered to be competent when he/she consistently
28 demonstrates the ability to transfer scientific knowledge from social, biological and physical

1 sciences in applying the nursing process, as follows:

2 “(1) Formulates a nursing diagnosis through observation of the client's physical condition
3 and behavior, and through interpretation of information obtained from the client and others,
4 including the health team.

5 “(2) Formulates a care plan, in collaboration with the client, which ensures that direct and
6 indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and
7 for disease prevention and restorative measures.

8 “(3) Performs skills essential to the kind of nursing action to be taken, explains the health
9 treatment to the client and family and teaches the client and family how to care for the client's
10 health needs.

11 “(4) Delegates tasks to subordinates based on the legal scopes of practice of the
12 subordinates and on the preparation and capability needed in the tasks to be delegated, and
13 effectively supervises nursing care being given by subordinates.

14 “(5) Evaluates the effectiveness of the care plan through observation of the client's physical
15 condition and behavior, signs and symptoms of illness, and reactions to treatment and through
16 communication with the client and health team members, and modifies the plan as needed.

17 “(6) Acts as the client's advocate, as circumstances require, by initiating action to improve
18 health care or to change decisions or activities which are against the interests or wishes of the
19 client, and by giving the client the opportunity to make informed decisions about health care
20 before it is provided.”

21 COST RECOVERY

22 10. Code section 125.3 provides, in pertinent part, that the Board may request the
23 administrative law judge to direct a licentiate found to have committed a violation or violations of
24 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
25 enforcement of the case.

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1 FIRST CAUSE FOR DISCIPLINE

2 (Gross Negligence and/or Incompetence)

3 11. Respondent is subject to disciplinary action pursuant to Code section 2761,
4 subdivision (a)(1), for gross negligence and/or incompetence in the practice of nursing in that she
5 claims her actions or failures to act were responsible for the deaths of two patients in her care
6 while she worked as an intensive care nurse at two Los Angeles hospitals between about 1969
7 and the early 1970s. The circumstances are as follows:

8 a. Los Angeles County General Hospital

9 While working as a registered nurse in the Surgical Intensive Care Unit of Los Angeles
10 County General Hospital in 1969 or 1970, Respondent undertook the care of LG,¹ a young
11 woman in extremely critical condition as a result of a car accident. LG was comatose,
12 unresponsive, and on life support, including a respirator attached to a tracheostomy through
13 which LG received oxygen. Respondent, who was caring for LG alone, noticed LG's oxygen
14 tank was running low. Respondent did not call for a replacement or otherwise bring the low tank
15 to anyone's attention. Respondent left LG alone to take a cigarette break. While she was gone,
16 the tank ran out of oxygen and the respirator stopped cycling, depriving LG of oxygen. When
17 Respondent returned to the unit a few minutes later, she saw an intern at LG's bedside. He had
18 removed LG's tracheostomy tube in the apparent belief that it was blocked. Respondent
19 explained that LG's tank ran out of air. No resuscitation efforts were made and LG expired. In
20 the aftermath of LG's death, Respondent lied to LG's husband about what had occurred and
21 failed to complete an incident report or otherwise accurately report her role in LG's death.

22 b. Mt. Sinai Hospital²

23 While working as a registered nurse in the Intensive Care Unit of Mt. Sinai Hospital in the
24 early 1970s, Respondent undertook the care of ML, an elderly man in an unresponsive coma and
25 on life support, including a respirator. ML required frequent suctioning of his lungs through his

26 ¹ Initials are used to protect patient privacy; full patient names will be provided upon
27 request during discovery.

28 ² Currently known as Cedars-Sinai Medical Center.

1 tracheostomy. After one such suctioning, Respondent left the room and forgot to reconnect the
2 respirator to ML's tracheostomy. She had previously turned off the respirator alarm. Shortly
3 thereafter, a telemetry nurse who was monitoring ML notified Respondent and her charge nurse
4 that something was wrong with ML's heart. Returning to ML's room, Respondent observed the
5 respirator connection lying on ML's chest where she had left it unattached to his tracheostomy
6 tube after suctioning him. She reconnected the respirator to ML's tracheostomy but the telemetry
7 nurse instructed her to disconnect it. Believing the respirator was interfering with the telemetry
8 readings, Respondent complied. ML expired and no resuscitation efforts were made. In the
9 aftermath of ML's death, Respondent told her charge nurse that ML was off the respirator when
10 Respondent returned to his room but the charge nurse did not reply. Respondent made no further
11 effort to explain what had occurred and failed to complete an incident report or otherwise
12 accurately report her role in ML's death.

13 PRAYER

14 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
15 and that following the hearing, the Board of Registered Nursing issue a decision:

- 16 1. Revoking or suspending Registered Nurse License Number 192219 issued to Penny
17 Perkins;
- 18 2. Ordering Penny Perkins to pay the Board of Registered Nursing the reasonable costs
19 of the investigation and enforcement of this case, pursuant to Business and Professions Code
20 section 125.3;
- 21 3. Taking such other and further action as deemed necessary and proper.

22
23 DATED: 12/30/10

Louise R. Bailey
LOUISE R. BAILEY, M.ED., RN
~~Interim~~ Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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